

peritoneal cavity and are carried about by the movements of peristalsis or even by the force of gravity, or perhaps their movements are aided by the ascitic fluid which is so frequently found in these cases. Where they become implanted they take on active growth and cause this widespread infection. There must also be a similar proneness for liberated cells to implant themselves in an operative wound.

THERAPEUTICS.

UNDER THE CHARGE OF

REYNOLD WEBB WILCOX, M.D., LL.D.,

PROFESSOR OF MEDICINE AND THERAPEUTICS IN THE NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL; VISITING PHYSICIAN TO ST. MARK'S HOSPITAL,

ASSISTED BY

HENRY HUBBARD PELTON, A.M., M.D.,

INSTRUCTOR IN MEDICINE IN THE NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL;
CHIEF OF THE MEDICAL CLINIC, PRESBYTERIAN HOSPITAL DISPENSARY, NEW YORK.

The Treatment of Malaria in Children.—CRESPIN (*La province médicale*, 1907, 24, 303) advises the administration of quinine, by mouth if there is no gastric disturbance, hypodermatically in the presence of digestive symptoms. The taste of the drug may be disguised by giving it encased in sugar or chocolate, in albolene or one of the fixed oils; it may be followed by a little lemon juice. Solutions for hypodermatic administrations should be largely diluted, and it is better to employ several injections of small size than a single large one. A useful formula consists of 35 to 45 grains of quinine bichloride to 150 minims of water. To this 30 grains of antipyrine may be added to increase the solubility of the quinine salt and to lessen the pain of the injection. The maximum dose for a child under two years is $7\frac{1}{2}$ minims; from two to five, 15 minims; from five to ten, 22 minims; from ten to fifteen, 30 minims. The tasteless quinine compounds, euquinine and aristochine, may be substituted for quinine for mouth administration. Certain adjuvants, notably arsenic, will materially increase the good effect of the quinine, and cryogenine is useful as an antipyretic in instances of hyperpyrexia, but has no influence on the infection. Laxatives are beneficial when the fever has disappeared and the digestion is sluggish and the liver and spleen are congested. In chronic malaria hydrotherapeutic measures may be employed, but douches over the splenic region may induce a malarial paroxysm. Splenic hypertrophy in children may be subjected to radiotherapy. In hemoglobinuria quinine should be given only in small doses and injections of artificial serum may be administered in order to supply mineral matter to the blood.

Renal Decapsulation in Eclampsia.—DE BOVIS (*La semaine médicale*, 1907, x, 109) has successfully treated a patient, in whom the ordinary forms of treatment had wholly failed, by decapsulation of the right

kidney. Previous to the operation the patient had suffered from repeated convulsions. After recovery from the anesthesia a considerable quantity of urine containing albumin was passed, but this manifestation disappeared completely within a few days. The particular point of interest is that this is the first instance of cure of eclampsia following the decapsulation of a single kidney.

The Treatment of Infantile Convulsions.—According to WEILL (*Journal de médecine de Paris*, 1907, xix, 26, 249), in addition to the usual means, chloroform inhalations, hot baths, ice-bags to the head, etc., we may employ, during the paroxysm, compression of the carotids, alternating between the right and the left if the convulsions are general; if they are unilateral the carotid of the opposite side should be subjected to the pressure, the compression being maintained for about four seconds at a time; the seizures should become less and less frequent as well as less intense after each compression. Leeches may be applied to the mastoid and malleolar regions. The injection of 1 to 2 ounces of artificial serum two or three times daily may be beneficial in eclamptic seizures with fever, dryness of the mucous membranes, dysuria, etc. In asphyxic spasms oxygen inhalations are advised and in laryngospasm rhythmic traction of the tongue and titillation of the pharynx may relieve the condition. In safeguarding the patient against recurrences our chief resources are hydrated chloral, the bromides, and antipyrine. The action of chloral is very rapid and the dosage for a newly born infant is $\frac{4}{1000}$ to $\frac{7}{1000}$ grain; for a nursing, from $\frac{7}{1000}$ to $\frac{1}{50}$ grain; such doses may be given three to five times daily; the rectal dose is double the above. The bromides may be given in doses of 15 to 45 grains per day. The child should be kept in as quiet a state as possible; proper feeding is very important and physical fatigue should be avoided.

Bismuth Subnitrate in Gastropathies.—HAYEM (*La quinzaine thérapeutique*, 1907, viii, 218) is an enthusiastic advocate of the use of bismuth subnitrate in stomach lesions. It is the agent of choice in ulcer, in which it hastens healing and lessens the pain and vomiting. In the pain of hyperchlorhydria the bismuth salt is far preferable to sodium bicarbonate, since the latter is not curative, but aggravates the disordered chemistry of the stomach which causes the pain. Likewise the bismuth relieves all forms of gastralgia when of organic origin, no matter what the chemical defect in the secretion of the organ may be. In ulcerating cancer it relieves the pain markedly, but unfortunately here the pain recurs when the medication is stopped. Not only is bismuth effective against pain, but it also relieves the sialorrhœa, emesis, and spasm of ulcer; it likewise relieves simple aërophagia, but is ineffective in the hysterical type of this affection. The best mode of administration is in doses of from 4 to 5 drams once daily. Small doses are less active and are more likely to cause constipation, though three doses a day of from 75 to 90 grains may be employed. When one dose daily is prescribed it should be taken ten to fifteen minutes before breakfast suspended in about a third of a glass of water. Administration of the bismuth, 5 drams in a half-pint of water, through the tube after lavage is advisable in some instances.

Morphine in Cardiac Dyspnoea.—HAY (*The Practitioner*, 1907, lxxix, 487) states that morphine is of recognized value in the treatment of cardiac dyspnoea, a fact easily recognized when one appreciates the fact that dyspnoea is largely subjective and that its severity bears no direct relation to the frequency of respiration or cardiac pulsation. Cardiac dyspnoea may be associated with two entirely different phases of arterial blood pressure, and in both of these morphine is useful. In patients with low pressure the trouble is primarily valvular. For these patients, when there is muscular failure, the morphine should be combined with digitalin or digitalin and atropine in order to tone the failing myocardium and at the same time to relieve the subjective sensations of dyspnoea. If the blood pressure is high, probably over 200 mm. of mercury, the morphine should be combined with a vasodilator, given by the mouth or hypodermatically. The drugs of the nitrite group and ammonium hippurate may be employed here.

Atropine in Acute Morphine Poisoning.—KOCH (*Klin.-thera. Woch.*, 1907, xiv, 737) has studied the action of these drugs upon men and animals and makes the following statements concerning them. In many instances of atropine poisoning enormous doses of morphine can be given, which shows at least that atropine is antagonistic to morphine. Reports of instances of mixed poisoning exist in which the morphine has been prevented from exerting its narcotic effect and its depressory action upon respiration. Numerous instances of morphine poisoning have been treated with belladonna and atropine and especially significant are those in which marked and rapid betterment has followed the hypodermatic administration of the latter. The instances in which atropine had no action or did harm may be explained upon the ground of improper administration of the antidote. In retrospect it would seem that atropine given in not too large doses, but still in sufficient quantity, is to be relied upon. The proper dosage would seem to be $\frac{1}{30}$ of a grain, given hypodermatically and repeated at intervals of sufficient length. The drug should be stopped as soon as the contracted pupil begins to dilate, this being the sign that the organism has received enough. In morphine intoxication atropine should not be our only resource, but other agents, such as caffeine, strychnine etc., and especially those which act upon the respiratory centre, should be employed.

Physostigmine Salicylate in the Prevention of Postoperative Intestinal Atony.—VINEBERG (*Surgery, Gynecology, and Obstetrics*, 1907, v, 184) considers that this drug is of some value in this connection; its use is free from danger and worthy an extended trial, and it would seem to be of especial value in counteracting the probable paralyzing effect upon the intestine of the morphine which most patients need during the first few hours after a laparotomy. Vineberg's patients received the physostigmine salicylate with the initial dose of morphine just as they were recovering from the effect of the anesthetic; 15 of the 37 patients observed experienced no need for an enema to relieve distention before the fourth day after operation, when they received a purgative; 1 patient expelled flatus in thirty hours; 4 patients needed an enema within twenty-four hours; to 3 an enema was given in thirty hours, to

3 in forty-two hours, to 7 in forty-eight hours, to 3 in seventy-two hours. Of 55 patients who received no physostigmine after operation the percentage of those who called for relief was much greater. The danger of the drug, in the author's opinion, is not so great as some observers believe; these consider that the peristalsis which it causes might, in the presence of small and unrecognized injuries to the intestine, be attended with serious results. Harm may also ensue when meteorism is already present, or when it is due to mechanical obstruction or peritonitis.

Antitoxin in Diphtheritic Paralysis.—PERRIN (*Revue médicale de l'Est*, 1907, 11, 356) cites an instance of diphtheritic sensory and motor polyneuritis affecting all four limbs and raises the question as to whether this complication would have supervened if the patient had been subjected to systematic antitoxin treatment after the nervous manifestations had begun. He considers that in this patient rapid relief would have ensued if injections of antidiphtheritic serum had been given frequently—say, every two or three days. Such frequent injections as these, however, should not be practised without precautions, for repeated injections, especially if the doses are large, may induce untoward effects. The patient should be kept on a fluid diet, the channels of elimination should be kept freely open, and upon the least sign of untoward reaction the injections should be stopped. Haushalter is quoted as having observed a series of experiments which lead him to think that antitoxin treatment is of decided value in the prevention of diphtheritic paralysis.

Veronal in Seasickness.—SCHEPELMANN (*Therapeutische Monatshefte*, 1907, xxi, 406), after an experience with a number of patients, concludes that in veronal we have a useful means of preventing and relieving seasickness. As a prophylactic he prescribes the drug in doses of 7½ grains; in the height of the ailment he gives 30 grains daily, if necessary, in divided doses of from 10 to 15 grains each. Certain patients under this treatment feel no symptoms of seasickness and are able to eat with gusto and to go about the deck at will; others are relieved of headache and nausea, but continue to suffer from vertigo and lack of appetite; in a few subjects the treatment is unavailing. If severe emesis is present the veronal is given by rectum in double the oral dosage, the drug being soluble in 150 parts of hot water. It seldom exhibits any cumulative effect, and, the therapeutic dose being much less than the toxic dose, no symptoms of poisoning are likely to be observed.

PEDIATRICS.

UNDER THE CHARGE OF

LOUIS STARR, M.D., AND THOMPSON S. WESTCOTT, M.D.,
OF PHILADELPHIA.

Differential Diagnosis Between Measles and Rubella.—H. M. McCLANAHAN (*Jour. Amer. Med. Assoc.*, 1907, xlix, 1916) thus sums up the differential diagnosis of measles and rubella. Measles always has a cough,